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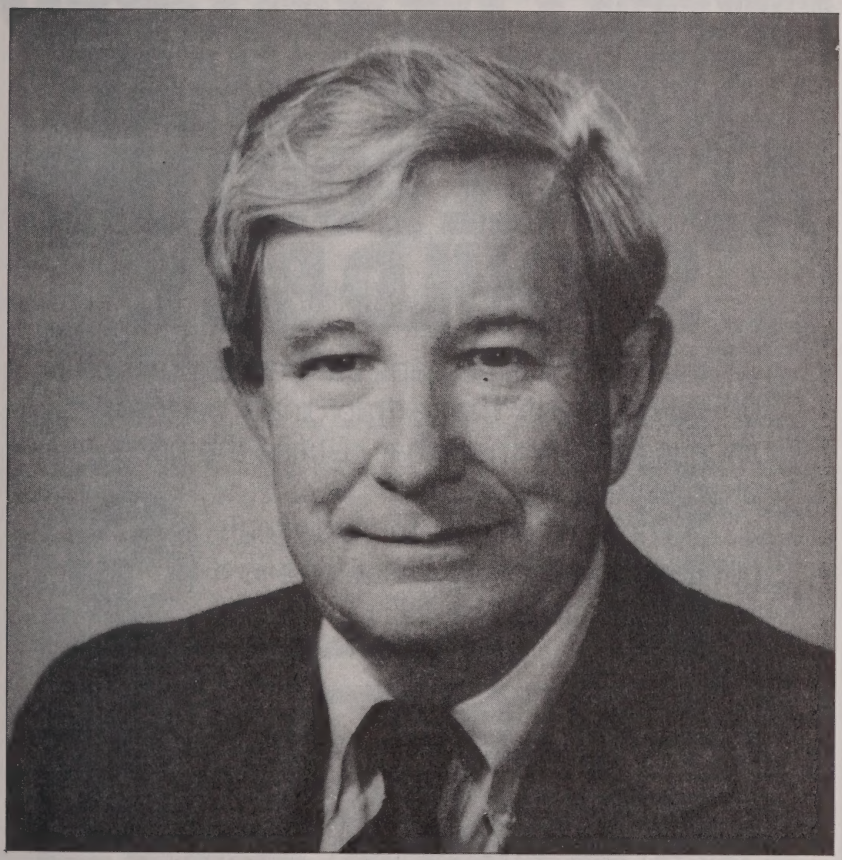

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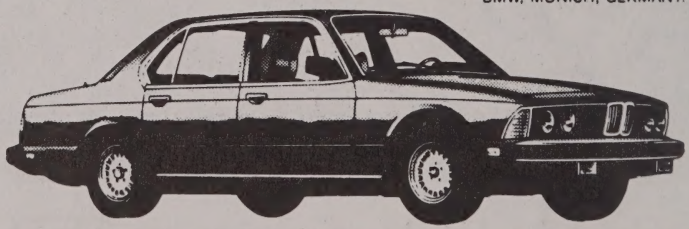

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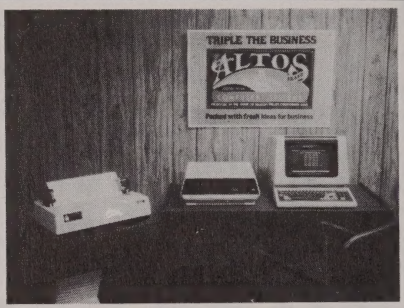

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Contents

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President's Page 6

Greetings from State 8

Letter to Assistant Commissioner
of Public Welfare 10

Light Duty 13

Pharmacy Corner 14

Is There an Effective Civil Defense
Against Nuclear Weapons? 16

Massachusetts Mutual High Blood
Pressure Control Program 19

Sister of Providence Health Care
for the Homeless 20

News from the Springfield Academy
of Medicine 21

Highlights of the Year, 1982-1983 of
the Auxiliary to the HDMS 22

On the Pill (An Ode to Amiodarone) 24

Welcome New Members 26

THE HAMPDEN HIPPOCRAT IS PUBLISHED MONTHLY EXCEPT FOR JULY AND AUGUST.
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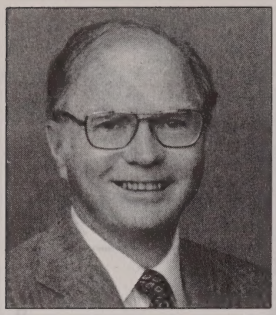

Terry D. Ryan, M.D.
President

PRESIDENT'S PAGE

TO SIGN OR NOT TO SIGN

The time of decision is fast approaching. Listening attentively, much of the discussion I hear points up to the deteriorated relationship the DPW has with the average physician. The thought expressed might best be summarized in the words of that ancient philosopher, Dr. R. Dangerfield, "I don't get no respect."

Sure there are complaints of the inequitable and arbitrary fee system, but I sense that even a reasonable fee structure would not soothe the anger many feel after the years of shabby disrespect the DPW has shown towards the medical community of this Commonwealth.

The Message we hear "VENDORS! We offer you a contract to treat our medically indigent, agreeing not only to the fee schedules which we will set, but also agreeing to practice and maintain records according to our arbitrary rules, while we deprive you of your right to choose whom you shall or shall not treat, harass you with audits, threaten you with fraudulent and criminal charges, and deprive you of any right to meaningful appeal," is demeaning. It would seem that honorable persons who have spent a decade or more of their lives preparing for a "learned profession" should not be asked to place themselves in such a self-compromising position.

A different message, such as "Gentlemen, the Commonwealth respectively request that you care for the medical needs of our poor. Sorry we cannot meet your financial aspirations at this time, but we will assist you in every other way possible to lessen your burden," might just lead to the enlightenment of all concerned.

So much for wishful thinking.

Allow me to call your attention to the pithy letter elsewhere in this issue, from your HDMS Committee on Tax Supported Medicine, Dr. Walther Tauber. (Now go read Walter's letter.) Walter's confrontational approach seems to have been most useful in bringing the Medicaid problem to the forefront. At the State level we have Dr. Gus Siragusa chairing the MMS Committee on Tax Supported Medicine; through its earnest efforts a completely unacceptable Medicaid Contract has been disposed of and replaced by a simpler and more straight forward contract. With the continued leadership of stalwarts such as Gus, the MMS Committee on Tax Supported Medicine appears to be in a good position for future negotiations with the DPW. We owe a great debt of

gratitude to the consistent efforts on our behalf of fellow physicians such as these.

Now you and I are faced with the decision to sign or not to sign. Should we sign an agreement giving the DPW the formal right to treat us in the haughty and disrespectful way that has been its custom in order to recieve substandard, and at times, token payment for our services? Or, should we not sign and

1. Treat those patients for a reduced or no fee.
2. "Dump those patients into the offices of our brother down the street.
3. Fill the hospital clinics and
   a. donate our time to these clinics or
   b. Hope that our friends will be more generous than we in donating their time.

Each physician must decide according to his own interpretations of the problem, but in making that decision he must not only consider his own self interest, but also consider the role he must play in the collective responsibility that all physicians share in the care of the citizens of our communities. □

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Greetings from State!

It is a distinct pleasure for me to bring you greetings from the Massachusetts Medical Society. I am pleased to have been elected your President for the next year. For those of you who attended the inaugural activities in Boston, I'm sure you are well aware of what a happy evening it was. Dr. Percy Wadman was given a very fine farewell, and I was given an equally magnificent welcome. We had one of the largest turnouts ever for a banquet and Annual Meeting.

Our scientific program had an attendance of over 800 members, a record for the Society. The scientific content of the meeting was excellent, and we have had many fine comments regarding the program.

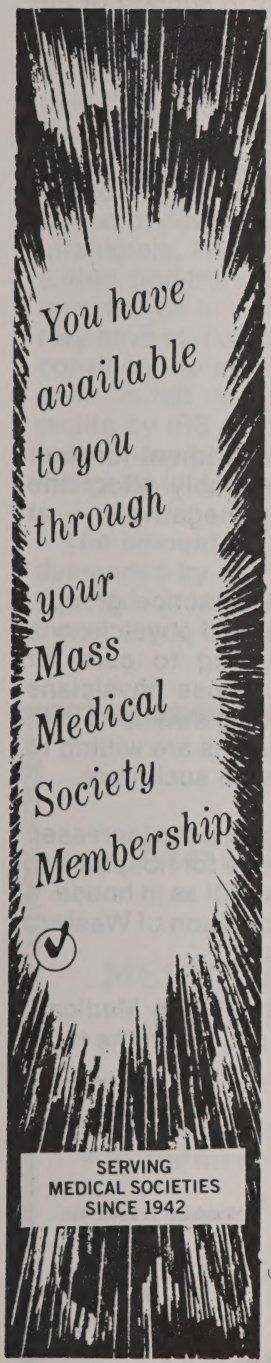
At the present time, the Society is vigorously engaged in attempting to hold down the requested increase in the JUA malpractice fees. Your President and the Committee on Professional Liability have been negotiating with the JUA, with the assistance of our lawyer and actuary. Hopefully, we will come to a solution which, although still an unpleasant increase, will be significantly less than that requested by the JUA.

The Blue Shield suit has now entered approximately its seventh week at trial and will probably last for several more weeks.

We have co-sponsored a video tape with the Massachusetts Hospital Association regarding the physician's role in Chapter 372. This tape is available on request from headquarters for display at your District Society meetings or at your hospital staff meetings; we hope that you will take advantage of this presentation. The Health Care Coalition, of which our Executive Vice-President, William B. Munier, M.D., on behalf of the Society, is a very active member, is working on amendments to Chapter 372 that will take care of some of the inequities in the law. Obviously, this law has to be tailored in many respects, but it certainly is a better program than that with which we would be dealing if the Federal program that is now being effected in the other states applied to Massachusetts. Because of Chapter 372, that Federal program does not affect Massachusetts for at least three years.

We look forward to a busy year. We intend to keep the open channels of communications which Dr. Wadman has established and continue to involve more and more people in the workings of the Society. Our first meeting of the District Presidents and the Executive Councilors on the 29th of June will really start off the year, and we hope to have your cooperation and continued interest in the Society. □

Goodwill M. Stewart, M.D.
President
Massachusetts Medical Society
1983-1984



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The following letter has been sent to Assistant Commissioner Beatrice from the Hampden District Medical Society in support of the efforts of the Massachusetts Medical Society Committee on Tax Supported Medical Care. This Committee had been dormant for several years before Dr. Siragusa of Hampden became its Chairperson.

Walter F. Tauber, M.D.
Chairperson, Tax Supported Medical Care Committe, HDMS

Dennis Beatrice
Assistant Commissioner of Public Welfare
600 Washington Street
Boston, MA 22111

Dear Mr. Beatrice:

The contracts submitted to physicians by the Department for their participation in MMIS and related matters will probably affect the health care of DPW clients very seriously and very negatively — at least in this part of the state.

Many physicians individually, and in established practice groups, are now refusing to see Medicaid patients. This group of physicians is rapidly growing. Reciprocally, the physicians willing to care for Medicaid patients are becoming fewer each day. Those physicians who are still waiting to serve Medicaid clients are being swamped with transfers from those who do not. Even fewer physicians are willing to sign a formal contract with the Department to provide such care.

The local hospitals do not have the facilities to absorb the increased work load. Indeed, Chapter 372 provides a disincentive for hospitals to open their doors to more patients — ambulatory, as well as in house. It is not inconceivable that a large segment of the population of Western Massachusetts will be left without any medical care.

The reasons for growing physician disenchantment with Medicaid are numerous. I should like to list those which, to me, seem the most

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important. I am further excluding from consideration those who — for whatever motives — never participated in Medicaid.

We are all aware that audits are necessary. However, it is the almost unanimous perception of physicians that audits, as conducted in the past, were unfair, destructive, harassing, and were not conducted in good faith by the Department. It is obvious, for instance, — or it should be obvious — that it defies logic that so many (a majority?) gynecologists were found to charge improperly for urinalyses over a period of several years, UNLESS the Department failed to issue clear, intelligible, TIMELY instructions. Several statiscians whom I have consulted, find the sampling — and reimbursement — model for billing errors, not be in conformity with proper statistical methods. While you may have statistical consultants with contrary opinions, you will never convince the medical community that the model used by the Department is fair or equitable. In this connection, please, note that tax audits by IRS are so conducted that corrections are possible — and sometimes do occur — which favor the citizen. The DPW audits are designed in a way which makes this completely impossible.

The amount of paper work required, exceeds greatly that which is demanded by any other agency, public or private. In addition to more detailed documentation rules regarding services rendered, and ordinary proof of eligibility, "providers" are faced with the need to:

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1) provide repetitive proof, from several sources, of eligibility, when the computer system has not been properly programmed. Incidentally, Department staff is unwilling, frequently, to make proper corrections in this regard.
2) perform more oneous billing procedures than required by other third parties (including CHAMPUS).
3) rebill, due to erroneous disallowances.
4) appeal and rebill for payments below published DPW fee schedules.
5) appeal and rebill for arbitrary underpayment after physician review.

It is abundantly clear from the above that the overhead costs of caring for Medicaid patients is excessively high by any standard. Yet, at no time, since the inception of the Medicaid program, have payments been realistic in regard to physicians' costs. Certainly, payments have never even approximated the fees available for the same services from other sources. Inflation over the past few years has accentuated this discrepancy and inequity. It is particularly noteworthy that around 1975, Massachusetts cut Medicaid fees even below their prior inadequate levels. Only recently have these cuts been restored, but without adequate consideration for the ever rising cost of living.

The contracts now before us have raised fears that the Department:
1) wishes to restrict access to administrative and judicial review and appeals for physicians,
2) will increase physicians' overhead (for those who participate) many fold by increased complexity of clinical records and billing,
3) will substitute the judgement of remote, anonymous physicians (who do not know the patient and who may only have a cursory knowledge of the specialty involved and whose primary concern is administrative and costcutting), for the judgement of the clinician who carries the true responsibility, and who deals directly with a real person in distress.
4) will find it possible to recoup most payments on the basis of technical errors. Thus, physicians would provide their services gratis.

There may be good arguments to refute each of the points made above. However, unless you can convince a sufficient number of physicians who would have to supply the services to patients, the entire program may collapse. It is not sufficient to persuade representatives of the Massachusetts Medical Society and of the constituent district societies. The Department, the Commonwealth, but most of all — the Medicaid population need to have rank and file cooperation from the medical community.

Very truly yours,

Walter F. Tauber, M.D.
Chairperson
Committee on Taxsupported Medicine
Hampden District of Massachusetts Medical Society

Light Duty

Most plants have work considered to be light duty. Among the problems, is that the line supervisor feels pressured by production demands and co-workers' demands to return the worker to normal duty, often prematurely.

In several area plants, a specific light duty area has been set aside for the purpose. Obviously, financial justification for its existence is necessary for the continued existence of such a department. Let's examine the reasoning of one such company.

In the case of Milton Bradley, their "light duty" department is called the Game Repair; wherein improperly assembled games are opened, disassembled and the components returned to production. The department, therefore, serves a valuable function to the production departments it serves. It also impresses the worker assigned to duty in the department that the work is not a phony make-work project. Yet, the department does not have production schedules, as such, and the worker can work at a pace suitable to their needs.

The most interesting medical use of this department is in the area of rehabilitation of the ailing worker, whose physician, perhaps an orthopedic surgeon, feels some easy, intermediate return to normal routines would be beneficial. Many times the worker has been brought in for part of a day, given hands-on treatment in medical, given time for therapy or other physician's recommendations; thus, re-establishing work patterns and removing them from a debilitating habit of idleness in their home, which is increasingly difficult to discontinue.

One of the stumbling blocks in the usefulness of such a department is the communication barrier which frequently exists between the physician and the industrial community. It follows that it is in the interest of good patient care that the medical community be receptive to the availability of such departments and understanding of the good intentions of the Safety Directors or Occupational Nurses offering such facilities. The greater involvement of physicians in this effort the better such facilities can perform and the broader the applicability of these light duty departments. □

Peter Nicholas
Safety Director
Milton Bradley

Editors' Note: The Greater Springfield Health Care Coaliton plans to conduct a seminar this fall concerning this subject and other pertaining to Workers Compensation problems. More information will appear in subsequent issues.

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Pharmacy Corner

Tom Cocchi and Ray Provost
Western Massachusetts Pharmaceutical Association

We appreciate the space the Hampden District Medical Society has offered to us in your newsletter. It is hoped that this communique will help both associations with our day to day contacts with patients and government regulations such as the Drug Enforcement Agency and the Welfare Department.

One of the problems that has increased in frequency is the passing of forged prescriptions; one or two per week and as many as two or three in one day. Drug users whose street supplies have been cut off will steal any kind of prescription blanks and forge prescriptions for Scheduled drugs, primarily Percodan, Percocet, Tylox, Demerol, Codeine, Dilaudid, and Seconal or Nembutal. The profits from the sale of these drugs is great. Tylox and Percodan have a street value of up to $4.00 per dose. Dilaudid 4 mg up to $45.00 per dose. We as phamacists are always on the look-out for forged prescriptions. When one is suspected, it is verified with the physician whose name is on the blank and the police may be notified if the person can be detained in the pharmacy. Also, the Western Massachusetts Pharmaceutical Association telephone network is notified and all the pharmacies in the Springfield area are called to make pharmacies aware of the stolen blanks. Unfortunately on occasion the forgery is so authentic it escapes detection, especially when filled away from the physician's area or out of town. With this in mind the Western Massachusetts Pharmaceutical Association make the following recommendations.

1. Prescription blanks to be used for Schedules 3,4,5, and 6 drugs which constitute 90% of the prescriptions written should have the warning on the blanks "NOT FOR SCHEDULE II DRUGS".
2. Prescriptions blanks to be used for Schedule II (i.e., narcotic drugs) should be secured in a safe place only accessible to the physician.

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The following are excerpts of Federal and State regulations for controlled substances:

Schedule II regulations which are being enforced are: the prescription must contain the patient's name and address, the date it was written, the name, strength and quantity of the medication. The quantity shall not exceed a 30 day supply, except for Ritalin and/or dextroamphetamine sulfate when used for Minimal Brain Dysfunction, i.e., hyperkinesis, narcolepsy, when a 60 supply is allowed. The physician must sign the prescription and include the address and DEA number (formerly BNDD number), and the Massachusetts Registration number assigned by the Department of Public Health. These prescriptions cannot be refilled.

Schedule II oral prescriptions are permitted only in an emergency. The prescription may be phoned-in by the physician or authorized representative in his presence. (Pharmacists are always on the alert for fraudulent prescriptions being called in by persons impersonating physicians). The quantity of medication prescribed shall not exceed an amount necessary to meet the immediate needs of the patient. A prescription must be forwarded to the pharmacy dispensing the order. If the prescription for the oral-emergency order is not received by the pharmacy or post-marked within 72 hours the pharmacist is mandated to report the physician to the regional office of the Drug Enforcement Administration.

Schedules III and IV may be oral or written prescriptions authorizing 5 refills or for 6 months whichever time is up first. Only a 30-day supply to be issued for Schedule III. Examples of these are Valium, Ativan, Tranxene, Fiorinal, Tylenol & Codeine and Tussionex.

Schedules V and VI may be oral or written prescriptions with quantities and number of refills at the discretion of the physician within the guidelines of usual medical practice; and up to the discretion of the pharmacist when filling the prescription.

It should be remembered that if no refills are indicated on the prescription it cannot be refilled; and it is the responsibility of the physician to forward a completed prescription blank covering III, IV, V and VI to the pharmacy within 7 days if given by oral authorization.

As a precondition for payment by the Welfare Dept. all prescriptions must follow Federal and State regulations. In addition the Welfare department does not recognize a prescription marked prn refill. A maximum of 5 refills if specified is allowed per prescription within a 6 month period. □

Is There an Effective Civil Defense Against Nuclear Weapons?

Since 1945 the arms race has been part of our lives. Currently we are going through the largest military buildup in peacetime history to close the "gap of vulnerability", to demonstrate our strength and will to the Soviets. Most of the people involved in this mission are military, the military-industrial complex and politicians. The vocabulary takes on an unreal quality i.e. counterforce, countervailing, C^3I, PGM, WAAM, BOSS, laser and particle beams. One is tempted to give up, and put energies into taking care of patients, and leave all of this to the "experts." Before doing this consider the question what would happen in a nuclear war? As you read let yourselves feel the message.

A one megaton nuclear missile (70X the Hiroshima bomb) dropped on Hartford would immediately kill 280,000 of the 650,000 populus; 160,000 would be incapacitated by fractures, lacerations and burn; those in shelters would die of suffocation from the 2,000 degree F heat. Within weeks survivors would be outnumbered by corpses. Most hospitals, physicians, health personnel, drugs and medical supplies would be gone. There would not enough morphine to dull the pain. In the weeks and months to come the infections would increase, food and water supplies would be disrupted and contaminated, starvation, epidemics, blindness and deafness would be commonplace.[2-7]

No one realistically expects only one missile. More probably is 100's to 1000's in which case there would be no effective outside help, no communication or transportation system, no social organization. In short our society and our ecology as we know it would be gone.

Is Civil Defense possible? The Reagan administration says yes, and is asking *4.3 billion dollars* for a seven year Civil Defense against

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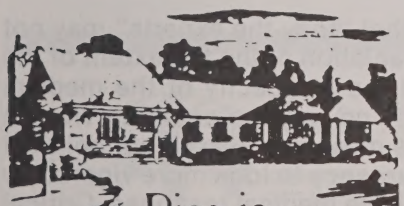
nuclear warfare that would entail massive relocation to show that we can "survive" a nuclear attack. We have no effective defense against the missiles. In the event of an attack we would have a warning of only *7-30 minutes*. It would be impossible to effect evacuation. The Civil Defense experts say that about *8 days* would be required for relocation. But what about a period of increasing tensions or detecting that Russia is relocating its people? (There is no evidence that Russia has practiced this, and in fact their road system would make it even harder than for us.) Jennifer Leaning MD. (Board Certified Internist and Emergency physician at Mt. Auburun Hospital, Cambridge, MA) has outlined the problems in relocating 145,000 people from 250 urban areas. The plans are poorly conceived, Boston would to to Cape Cod which has one bridge and there are no real plans for food and shelter. Completing plans will take 8-10 years by which time our whole situation will be different. And what is to stop the Russians from simply redirecting their targets? Meanwhile Springfield area residents are to go to Amherst which is less than 50 miles away and we have been refused there anyhow.

However, for the sake of discussion if 80% were relocated that leaves 58-72 million deaths in a 6-10,000 MT (megaton) war with 3-5 days "warning". There would be 25-30 million *casualties* of which 50% would die in 30 days. In the first year 40% more would die from multiple causes giving *132,000,000* to *142,000,000* deaths in the first year. Of those who remain it is calculated that 40% more will die in the second year leaving 25% of our original population. All this without any



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social organizations or our usual ecology. Clearly society as we know it will have ceased to exist.[8]

Civil Defense can not change what the weapons do: CD can not protect our structures, our organization or the society. In fact in so far as it leads people to believe we could "survive" an attack it deceptively leads people into accepting that a nuclear war might occur. This decreases the urgency to do everything possible to prevent it.

As the American Medical Association has stated that there is "no adequate medical responses possible." *Prevention is the only medical approach.*

Is the risk increasing? This is difficult to answer exactly, but the Union of Concern Scientists say the risk is greater than ever before. Increasing numbers of missiles, decreasing warning time, increase use of computors, increased awareness of the 4% incompetency of the operators at missile bases, increased availability of nuclear weapons to other nations, and recognition of the vulnerability of our communication system all increase the the chances of nuclear war. Remember everything said here holds true for the Russians too! It is in their best interest to avoid a nuclear war, and infact they have adhered to all 12 treaties on nuclear armaments. But do we want to depend on the Russians good judgment in the tensions of conflict? For that matter, do we want to depend on our own judgment? Hopefully the risk is low, but what is the risk over the next 30-50 years? Can we guarantee our children and grandchildren that this will never happen? Not even once?!

As physicians we know something that "they the experts" may not know but should know. That is an appreciation of the full extent of the human damage that would result and the incapacity of the medical profession to respond. There simply is no way we could survive let alone "win" a nuclear war. Making this message clear to our political leaders and increasing their sense of urgency to look more vigorously for a means of prevention is our only viable medical response. Critical and creative appraisal of our policies of increasing weapons is needed desperately.

Whether the danger comes from ignorace, fear, inertia, incompetent bureaucracies, or symbiosis with the military industries, when the health of the public is threatened, doctors should act. □

DOUGLAS BARNSHAW, M.D.
Public Health Committee

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Massachusetts Mutual High Blood Pressure Control Program

The HBP Control Program will soon be entering its seventh year. Basically, the program consists of the voluntary screening of employees for hypertension with referral to physicians in the community for care. All expenses are paid by Massachusetts Mutual. As personal physicians you have been an integral part of the program.

Voluntary participation of employees in the screening process approximate 98%. Of those found to be hypertensive, 78% are in full compliance with their treatment and 82% of these have their hypertension controlled. These are very good results.

It has been estimated that the employees experienced only one-third the number of cardiovascular crises and one-fourth the mortality which would be predicted from national data. In addition, the monetary savings from the program now significantly exceed the expenses.

Massachusetts Mutual and its employees are most appreciative of the treatment provided by area physicians, and the excellent results are a reflection of the high quality of care given.

This serves as an excellent example of preventive medicine, of the cooperation of the many who have participated in the program and of a successful effort in cost containment. □

JOHN R. S. REMSBERG, M.D.
Medical Director

Valley Vascular Diagnostics

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Sisters of Providence Health Care for the Homeless

The Sisters of Providence are committed to meeting the health care needs of the residents of the Greater Springfield community. There are, however, subgroups of this population for whom meeting these needs is particularly difficult. Probably the most difficult group to provide health care services for is the homeless. The homeless do not use the traditional health care system yet are very needy. To address their needs the Sisters of Providence will sponsor a special program of health care services, including prevention, education and diagnosis for the homeless. While this program is not a subsitute for the comprehensive primary medical or hospital care, it is designed to alleviate the suffering of "street people" who are destitute and in need of health care. There are specific health care problems which plague the homeless and the need for early medical intervention is obvious. Without intervention the medical problem will usually become more acute so that eventually, acute hospitalization will be necessary. This results in increased inconvenience and/or discomfort for the patient, the use of increasingly limited health care resources which might have been avoided, and an increased financial cost to the health care system.

Dr. Oscar Nepomuceno will volunteer his time as medical consultant and staff the clinic one night per month. Other physicians who are willing to donate one evening a month from 5-7 p.m. are encouraged to do so.

Sister Julie Crane, nurse practioner assisted by volunteer nurses and assistants will provide outreach care at congregating sites of the transients Monday thru Friday from 12 noon to 7 p.m. starting July 5, 1983.

Further information regarding volunteers will be in the next newsletter. □

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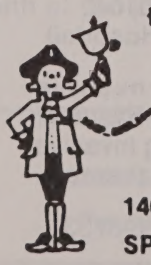

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NEWS FROM THE SPRINGFIELD ACADEMY OF MEDICINE

The S.A.M. is pleased to announce that we now have available to members the following material provided by Dr. Walter W. Williams.

SPERMATIC CYTOPATHOLOGY AND POTENTIAL FERTILITY
25 pages—12 illustrations by Dr. W. W. Williams

About 10% of intractable marital sterility and much impaired fertility is due to spermatic cytopathology. Information in this article should greatly improve the evaluation of spermatic cytopathology in terms of potential fertility.

BIOOGISCHE UNTERSUCHUNGEN
Gustav Retzius—1909

This limited edition was distributed to several European libraries as well as a few friends of the author. It is quite possible that the S.A.M. library in the U.S. is the only library to house this volume. It presents the mophological characteristics of the spermatozoa of many different species, including mammals, birds, reptiles, fish and insects. Though written many years ago, it remains the authority on this subject, excepting the information gathered by the use of the electron microscopy. It will be of value to those engaged in biological studies who desire to include the identification of spermatic cytopathology as part of their infertility diagnostic programs since it is evident that most infertility or sterility of the male is associated with easily identified spermatic cytopathology which arises from an alteration of one or more structural components of the cell and affect a relatively large ratio of the sperm population.

Copies of the article by Dr. Walter W. Williams can be obtained from the Springfield Academy of Medicine Library for $15.00. The book by Gustav Retzius is available at the library but is not available for loan.

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HIGHLIGHTS OF THE YEAR 1982-1983 OF THE AUXILIARY TO THE H.D.M.S.

Dedication and commitment have sped the Auxiliary ahead in achievements, on a community, state and national level.

1. Participated at the invitation of Dr. Hough, President of the Hampden District Medical Society in a wine and cheese party for housestaff at Baystate Medical Center.

2. Published the attractive membership yearbook with the new Auxiliary logo on the cover.

3. Launched the first program on Physical Fitness.

4. Holiday Tea held at the home of Luciana Navazio.

5. Joint meeting in January with the H.D.M.S. to meet and greet our Legislators.

6. Five $500.00 scholarships to worthy applicants were awarded.

7. Welcome Wagon committee visited new medical families within the area and resulted with eight new members to the Auxiliary this year.

8. The Public Relations correspondents have supplied the Hampden Hippocrat with articles and the October issue was devoted to the Auxiliary.

9. $250.00 raised in the Holiday Share a Card campaign for AMA ERF. $240.00 raised from the sale of tote bags.

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10. The Health Education committee met monthly at the Museum of Science creating two health kits on the respiratory system.

11. The Heart Kit was featured in the September issue of FACETS published by the Auxiliary to the AMA.

12. TAM, the Transparent Anatomical Mannikin will be installed at the Museum of Science during the summer of 1983. Get involved with the Health Hall.

13. STRESS AND ITS EFFECTS ON ADOLESCENCE was the topic of the Seminar held in March at the Springfield College. Two hundred persons were in attendance. This was a wonderful community project with over 3,000 mailings.

Thanks to all Auxilians of the Hampden District Medical Society from Audrey Rich, President for this fruitful year. □

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On the Pill
(An Ode to Amiodarone)

I hoped the day might come, at last,
When Amiodarone had passed
The rigid tests of FDA
To be prescribed in USA.

Perhaps, with just a gentle nudge
I'd get the FDA to budge;
And, separating fact from fiction.
Give this new drug their benediction.

And so I wrote this little rhyme
In hope of speeding up the time
When this great drug its role might play
In folks who hearts 'gang aft agley!'

Now I've a ticker prone to sputter
With penchant for recurrent flutter
That called for paddles, used as tools
To 'zap' me with a hundred joules.

A time or two was not so bad —
But fourteen 'zaps' in all, I've had
Plus drugs to keep on the ball
'Dig', quinidine and Inderal

I'd had no caffeine-drinks at all
And not a drop of alcohol,
And certainly was never seen
Inhaling 'nasty' nicotine

But that's all changed and for the best
A Belgian pill's been put to test —
Absorption, half-life, and what's more
Effects on Phases 1 to 4.

The mode of action's still not known
Slow-channels function on their own.
I'll let the drug work as it will
As long as I am *'on the pill'.*

For I am still arrhythmia-prone
When not on Amiodarone,

But as I sit and write this poem
My heart beats like a *metronome.*

So far, no side-effects I spy;
No 'jolly giant of green' am I
No iodine to worry about —
May 'cuz my thyroid's 'out'.

But now, more recently, I've heard,
In chiding FDA I erred,
For they're not holding up the deal;
The drug firms are — and that's for real.

And so before this 'orphan' drug,
With neither 'Ma' nor 'Pa' to hug,
Is manufactured in a lab
Some drug house must pick up the tab.

They've been afraid of side-effects
But when compared with heart defects
And all are in the balance weighed
A final judgement must be made.

For pigment-spots tend to be found
At corneal base — not all around,
They leave the vision clear and clean
And only by slit-lamp are seen.

But I'd prefer to have these spots
To other scrapes — and I've had lots —
For 'zapped' in Lima I have been
But not with synchronized machine.

It hit the down-slope of the T'
Ventric'lar 'fib' it gave to me,
These brown spots I prefer by far
To 'endo' tube and CPR.

Of course, it has been quite a thrill
To tell my friends, "I'm on the pill!"
They nearly faint right on the spot,
But the *pill* they think it is — it's NOT.

SAMUEL F. POTSUBAY, M.D. F.A.C.P.
Holyoke, MA 01040

Welcome New Members

Ruby Chang, M.D.
759 Chestnut St.
Springfield, MA 01107
(Resident)

BORN:	September 7, 1956
PREMED:	School of Medicine National Taiwan University 1975-82
MEDICAL:	School of Medicine National Taiwan University 1982
INTERNSHIP:	National Taiwan University Hospital 1981-82
RESIDENCY:	Baystate Medical Center 7/82 - present

Leonard Y. Wagner, M.D.
780 Chestnut St.
Springfield, MA 01107

BORN:	April 29, 1950
PREMED:	Middlebury College 1968-72
MEDICAL:	State University of New York at Buffalo School of Medicine 1973-77
INTERNSHIP:	University of Vermont 1977-78
RESIDENCY:	University of Vermont 1978-81
FELLOWSHIP:	Harvard University School of Medicine 7/81-12/81 Hand Surgery Association, Louisville, KY 1/82-6/82
SPECIALTY:	ORTHOPEDIC SURGERY

John Landis, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN:	January 22, 1943
PREMED:	Pennsylvania State University 1961-65
MEDICAL:	Temple University School of Medicine 1965-69
INTERNSHIP:	Baystate Medical Center 1969-79
RESIDENCY:	Baystate Medical Center 1970-71 Hospital of Medical College of Pennsylvania 1971-72
SPECIALTY:	INTERNAL MEDICINE/PULMONARY

Jeffrey Loman, M.D. (RESIDENT)
759 Chestnut St.
Springfield, MA 01107

BORN:	January 10, 1956
MEDICAL SCHOOL:	Case Western Reserve 1978-82
INTERNSHIP:	Baystate Medical Center 1982-present

Melissa Smith, M.D. (RESIDENT)
759 Chestnut St.
Springfield, MA 01107

BORN:	August 5, 1947
MEDICAL SCHOOL:	University of Mass., Worcester 1976-80
INTERNSHIP:	Baystate Medical Center 1980-81
RESIDENCY:	Baystate Medical Center 1981-present

Dianna Branson, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN:	August 4, 1955
MEDICAL SCHOOL:	University of Oklahoma College of Medicine 1977-82
INTERNSHIP:	Baystate Medical Center 1982-present

Maureen Beursuens, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN:	April 1, 1955
MEDICAL SCHOOL:	Univeristy of Mass, Worcester 1977-81
INTERNSHIP:	Baystate Medical Center 1981-82
RESIDENCY:	Baystate Medical Center-present

Thomas Hewitt, M.D.
20 Maple St.
Springfield, MA 01103

BORN:	January 7, 1952
MEDICAL SCHOOL:	Tufts University 1973-77
INTERNSHIP:	Baystate Medical Center 1977-78
RESIDENCY:	Baystate Medical Center 1978-80
SPECIALTY:	INTERNAL MEDICINE

Kelly Armstrong, M.D.
759 Chestnut St.
Springfield, MA 01107 (RESIDENT)

BORN:	October 23, 1954
MEDICAL:	University of New Mexico School of Medicine 1977-81
INTERNSHIP:	Baystate Medical Center 1981-82
RESIDENCY:	Baystate Medical Center 1982-present time

Jean R. Talati, M.D.
MEDICAL WEST
444 Montgomery St.
Chicopee, MA 01020

BORN:	November 29, 1951
MEDICAL:	Medical College of Zambia 1971-76
INTERNSHIP:	Berkshire Medical Center, Pittsfield 1977-78
RESIDENCY:	Berkshire Medical Center, 1978-81
SPECIALTY:	OBSTETRICS & GYNCOLOGY

Bret Coughlin
168 Franklin St.
Feeding Hills, MA 01030 (STUDENT)

BORN:	August 13, 1959
PREMED:	U.S. Naval Academy 1977-79 Holy Cross 1979-81
MEDICAL:	University of Massachusetts 1981-present

Anselmo M. Briones, M.D.
42 Ridgewood Terrace
Springfield, MA 01105

BORN:	April 21, 1933
MEDICAL:	University Sto. Tomas, Philippines 1953-59
INTERNSHIP:	University Sto. Tomas 1958-59
RESIDENCY:	Qurino Memorial General Hospital Quezon City, Philippines 1962-71
SPECIALTY:	OBSTETRICS & GYNECOLOGY

Elaine M. Francis, M.D.
444 Montgomery St.
Chicopee, MA 01020

BORN:	January 21, 1951
MEDICAL:	Tulane Medical School 1975-79
INTERNSHIP:	VA Wadsworth Hospital Los Angeles, 1979-80
RESIDENCY:	VA Wadsworth Hospital Los Angeles, 1980-82
SPECIALTY:	INTERNAL MEDICINE

Alan L. Dayno, M.D.
575 Beech St.
Holyoke Hospital
Holyoke, MA 01040

BORN:	August 31, 1951
MEDICAL:	Temple University School of Medicine Philadelphia 1974-78
INTERNSHIP:	Baystate Medical Center 1978-79
RESIDENCY:	Baystate Medical Center 1979-81
SPECIALTY:	INTERNAL MEDICINE / EMERGENCY MEDICINE

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Richard Steingart, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN:	April 18, 1950
PREMED:	Case Western Reserve University 1968-72
MEDICAL:	Tufts University School of Medicine 1972-76
INTERNSHIP:	University of Virginia 1976-77
RESIDENCY:	University of Virginia 1977-79
FELLOWSHIP:	University of Virginia/Hematology 1979-80 Tufts New England Medical Center 1980-82
SPECIALTY:	HEMATOLOGY/ONCOLOGY

Kevin W. O'Neil, M.D.
121 Main St.
Monson, MA 01057

BORN:	December 2, 1949
PREMED:	Boston College 1969-72
MEDICAL SCHOOL:	Georgetown University
INTERNSHIP:	Washington Hospital Center 1976-77
RESIDENCY:	University of Massachusetts Medical Center
SPECIALTY:	INTERNAL MEDICINE

David H. Miller, M.D.
2150 N. Main St.
Springfield, MA 01104

BORN:	August 13, 1945
MEDICAL:	Ohio State University Medical School 1967-71
INTERNSHIP:	University of Minnesota Hospitals 1971-72
RESIDENCY:	University of Minnesota 1972-1974
FELLOWSHIP:	University of Pittsburgh 1976-78
SPECIALTY:	RHEUMATOLOGY

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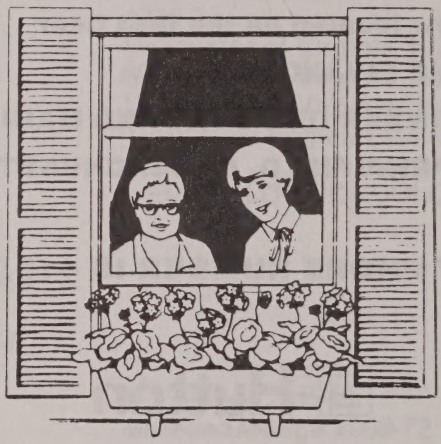

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